Canad. M. A. J.
June 1, 1957, vol. 76

ventricular fibrillation. These abnormal rhythms frequently manifest themselves as tachycardia or irregularity of heart action, two findings which unfortunately are often considered indications for digitalis or quinidine therapy. For example, the finding of bidirectional ventricular tachycardia is almost pathognomonic of digitalis intoxication; auricular tachycardia with block ("atypical flutter") is usually due to overdosage of digitalis, with or without potassium depletion; fast "regular" auricular fibrillation with fine "f" waves is very suggestive of too much digitalis. If, by mistake, additional digitalis is given under these circumstances, a reversible condition may be made irreversible.

Because of the large number of people who now have chest radiographs, the first clue to a curable or reversible form of heart disease is often noted by the radiologist. The outstanding example is the finding of notching of the ribs due to coarctation of the aorta. It is worth noting, however, that this finding is not as a rule detectable under 12 to 15 years of age.

A prominent pulmonary artery segment is a valuable finding as it commonly occurs in diseases that can be greatly helped such as mitral stenosis, atrial septal defect, patent ductus arteriosus, pulmonary stenosis (with poststenotic dilatation), and multiple pulmonary embolization. A prominent pulmonary artery segment with avascular lung fields is a frequent finding in patients with pulmonary stenosis.

In a child, when the question arises of a "vascular ring", such as a double aortic arch causing tracheal compression, it is comforting to know that a radiologist can usually give us a definite answer regarding the presence of this curable condition.

RÉSUMÉ

Toutes les maladies de cœur ne sont pas incurables et l'auteur s'efforce de le prouver en puisant dans son expérience personnelle. Les causes d'erreur prognostique les plus fréquentes seraient: un diagnostic mal fondé pour ne pas avoir éliminé les possibilités étiologiques, pour avoir négligé certains signes physiques par un examen incomplet, ou par une mauvaise interprétation des renseignements obtenus. L'anamnèse joue ici un rôle aussi important que dans n'importe qu'elle autre genre d'affection; ainsi la dyspnée, la cyanose et l'accroupissement chez un enfant évoquent immédiatement l'anomalie congénitale. Par contre toutes les arthralgies passées ne sont pas nécessairement rhumatismales, et il faut se garder de sauter aux conclusions. Le pouls bondissant de l'insuffisance aortique, des fistules artérioveineuses, du canal artériel, de la grande anémie ou de l'hyperthyréose peut se révéler à la simple observation des carotides. La péricardite constrictive en présence d'ascite et de pression veineuse élevée présente des traquenards semblables aux orteils hippocratiques et au pouls poplité diminué et décalé de la coarctation de l'aorte. La défaillance cardiaque permet rarement les changements brusques de posture, les mouvements rapides doivent faire songer à une hyperthyroïdie fruste. Les lésions cutanées offrent souvent les meilleurs indices diagnostiques de la maladie d'Osler. Une tension artérielle élevée aux bras doit être vérifiée aux jambes. Bien qu'onéreuse, il faut aussi procéder à la recherche des phéochromocytomes. Un pouls uniformément identique et régulier en toute occasion permet de soupçonner une foyer ectopique et un flutter. L'importance de l'auscultation, de l'intensité des sons, de la présence de bruits adventices ou de murmures, n'a pas à être répetée ici. Il en va de même pour l'interprétation judicieuse de l'électrocardiogramme et de la radiographie pulmonaire.

Case Reports

A CASE OF FATAL SHOCK FOLLOWING ORAL PENICILLIN

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SINCE THE ADVENT of penicillin therapy some years ago, we are becoming accustomed to reading reports of anaphylaxis and allergic reactions following its usage. More recently oral penicillin has been introduced as an effective method of treatment, and there have been fewer reports of allergic reactions following this method. As far as I can ascertain, there has been only one case reported of fatal anaphylactic shock in an adult after oral administration of penicillin[1] although several cases of allergic reactions have been reported. I would like to present a case of anaphylactic shock in a child after oral penicillin, which had fatal results.

Present history.—The child, a girl aged two years, was seen in the office on July 16, 1956, complaining of a sore throat with slight cough. The sore throat was of two days' duration and had become progressively worse. The cough was non-productive, and was hacky in character. The child's nose had been running for the past 24 hours.

Past history.—She had had an attack of acute tonsillitis in September 1955, which had been treated with oral penicillin (Bicillin-Wyeth) 100,000 units 4-hourly, without reaction. She had had no other illnesses of note.

Family history.—The paternal side of the family showed no allergy, although the grandfather has epilepsy, controlled well with Dilantin therapy. On the maternal side, two aunts had eczema as children, which had required treatment, but had had no allergic phenomena since.

Present examination.—The child looked healthy and was in no obvious distress. She was not cyanosed, dys-

pnœic or wheezing. The throat was moderately inflamed with a mild attack of tonsillitis; no membrane or slough was noted. The nose was mildly injected; ears and drums normal; no adenopathy; thyroid not palpable; chest clear; heart clear; abdomen normal. There was no meningismus.

Diagnosis.—Mild acute tonsillitis and pharyngitis.

Treatment.—V-Cillin Pædiatric Drops (Lilly) 50 mg. o.h. 6.

Post-treatment course.—Upon arriving home the mother gave her the prescribed dose of medication, which was taken without fuss. About 20-30 minutes later, the child became somewhat wheezy and dyspnœic. This became progressively worse until I was called (about 40 minutes from her ingestion of the medication), at which time she was rushed to hospital. She lived about three miles from town, and it was several more minutes before arrival at hospital, by which time the child was very dyspnœic, wheezy, and moribund. Her entire body was severely cyanosed, she was in a stupor, her pulse was very weak at a rate of 156, her chest was full of inspiratory and expiratory wheezes, and she was obviously in poor condition. She was moved to the operating room, intubated without difficulty, and given oxygen under positive pressure from the gas machine. She was given adrenaline, 5 minims intravenously (with almost no effect), and she died in a few moments' time.

DISCUSSION

A case of anaphylactic shock after oral administration of penicillin is presented. Unfortunately, certain things were omitted which would make this report more complete, these omissions being understandable under the tension prevalent at such a time, especially when the victim's parents were personal friends. An autopsy would have been of interest, but the parents did not want one. The remainder of the bottle was not checked to make sure the right product was given. Also it was unfortunate that there was no Solu-Cortef (hydrocortisone solution) available in the hospital at that time, since this has been suggested as the treatment of choice in such cases. (This has naturally since been remedied.)

In review, I think that this case teaches us that penicillin is not a drug to be used unless definite indications are present, because even with the apparently safer oral route of administration, there still lies a danger of an occurrence which can be heartbreaking, not only to the patient's relatives but also to the doctor in charge.

I would like to thank Dr. D. Murray Young, of the Connaught Medical Research Laboratories, and Dr. C. Collins-Williams for their help in reviewing this case in preparation for its publication.

REFERENCE

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SQUAMOUS CELL CARCINOMA OF THE TONSIL*

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MALIGNANT TUMOURS arising from the epithelium and lymphoid tissue of the tonsil are rare, and according to Eggston and Wolff[1] differ clinically and pathologically from similar tumours found elsewhere in the body. Each case therefore deserves special consideration to further the better understanding of tonsillar cancer. The following is a report of a case of squamous cell carcinoma of the tonsil.

N.T., a 78-year-old white man of normal stature, came to my office on May 10, 1956, complaining of sore throat and a lump in his neck. He had first noticed this eight weeks before on the left side. The soreness of his throat was rather mild in nature, occasionally radiating to the left ear, and not related to a cold. His general health was not disturbed and his past history was irrelevant. On first examination of the pharynx the left tonsil appeared larger in size than the right one. The lower half of the left tonsil was extensively ulcerated and infiltrated. Both anterior and posterior pillars were involved and markedly thickened. When probed, the diseased tissue appeared fragile but did not bleed easily on touching. The neck was rather thin and there was a single lymph node palpable, the size of a small walnut, below and behind the left mandibular angle, not tender on palpation, but stony hard and firmly attached to the underlying tissues. The skin over the lymph node appeared normal and movable. Other otolaryngological findings, except for a right-sided septum deviation, were within normal limits. The temperature was normal, the lungs were clear, and nothing relevant was found during the routine physical and laboratory examination, serology included. Radiographs of neck and chest were normal. The differential diagnosis excluded Vincent's angina, syphilitic gumma of the tonsil, tuberculosis of the tonsil, lymphatic leukæmia, agranulocytosis, and infectious mononucleosis. The patient was admitted to Yorkton General Hospital where a biopsy specimen was taken under local anæsthesia in order to differentiate between possible involvement of the tonsil in generalized reticulo-sarcoma, Hodgkin's disease, and sarcoma or carcinoma of the tonsil. Histological examination (Dr. N. L. Hoffman, Regina, pathologist) disclosed a malignant tumour of the tonsil, as shown in the photomicrographs (Figs. 1 and 2).

"Histological examination reveals a squamous cell carcinoma. The clothing stratified squamous epithelium of the tonsil shows hyperplasia of the malpighian layer with much vacuolization. One area is ulcerated and the adjacent epithelium displays marked disorderly arrangement and atypicality of the rete cells. Irregular downward proliferations are growing deeply into the underlying lymphatic tissue but obviously true invasion by islands of atypical squamous cells is also occurring. The component cells are rather pleomorphic and vary also in size. They have well-defined, deeply eosinophilic cytoplasm and round to oval, intensely basophilic nuclei. Mitotic figures are frequently encountered. In the centre of some cell masses necrosis is seen, as well as

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Read before the North-Eastern Saskatchewan District Medical Society on July 25, 1956.